STATEMEN	F OF HEALTH AND HUM R MEDICARE & MEDICA TOF DEFICIENCIES OF CORRECTION			LDING	INSTRUCTION 00		RM APPROVED IB NO. 0938-0391 SURVEY LETED
NAME OF PROVIDER OR SUPPLIER PASSAGES INC		•	125 NO	ADDRESS, CITY, STATE, ZIP CODE RTH 200 EAST IBIA CITY, IN46725	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0000	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: September 13 and 14, 2011. Facility number: 000658 Provider number: 15G121 AIM number: 100234300 Surveyor: Kathy Wanner, Medical Surveyor III		W	0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

The following federal deficiencies also reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9/21/11 by Ruth Shackelford, Medical Surveyor III.

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the

facility failed to ensure the direct care

Incidents of Abuse, Neglect, Exploitation,

Etc. policy as indicated in 1 of 24 Bureau

(BDDS) reports for 1 of 4 sampled clients

of Developmental Disabilities Services

staff were following the Reporting

TITLE

employee was terminated.

How will we identify otihers residentis having tihe potiential tio be

afiectied by tihe same deficienti

Whati corrective action(s) will be

accomplished fior tihese residentis

A ftull investgaton oft the allegaton

oft verbal abuse toward client#1 was

completed. The allegaton oft abuse was substantated, and the

deficienti practice

fiound tio have been affectied by tihe

(X6) DATE

10/02/2011

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

(client #1).

Findings include:

W0149

Event ID:

OVTB11

W0149

Facility ID:

000658

If continuation sheet

li ´		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED)
		15G121	B. WIN	IG		09/14/2011	
NAME OF	PROVIDER OR SUPPLIEI	2		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
THE OF THE VIBER ON COLLEGE				1	PRTH 200 EAST		
PASSAG	SES INC			COLUM	IBIA CITY, IN46725		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CON	MPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					practice:		
	Facility records	were reviewed on 9/13/11			Staft training regarding Passages		
	at 1:59 P.M. inc	luding the BDDS reports			policy to prohibit abuse, neglect,		
	between the date	es of 11/10/10 and			and mistreatment was provided to all staft working in this home.	·	
	9/13/11. The BD	DDS reports indicated the			Whati measures will be puti intic	.	
	following:	•			place or whati systiemic changes	I	
					be made tio ensure tihati tihe		
	- a BDDS report	dated 8/12/11 for an			deficienti practices do noti recur		
	1 ^	/11 at 7:15 A.M. indicated			Staft training regarding Passages		
					policy to prohibit abuse, neglect,		
	"On 8/11/11 [client #1] reported to the Qualified Developmental Disabilities Professional (QDDP) that he had a situation in the group home this morning				and mistreatment is provided upo	n	
					hire and annually thereafter		
					How will tihe corrective actions b		
					monitiored tio ensure tihe deficie practice will noti recur	nti	
		Client #1] said he got up			QDDP will ensure training is		
	1 -	nower in the morning			provided regarding Passages abus	e.	
	1	ing to be out with his			neglect, and mistreatment policy	,	
	mother in the aft	ternoon, when it was his			upon hire and annually thereafter	by	
	assigned shower	time. A staff member			reviewing training documentaton		
	[staff #10] 'got is	n my face and was yelling			annually and when new employee	s	
	at me and being	disrespectful to me.' An			are hired.		
	investigation wa	s started. On 8/11/11 at			QDDP will ensure all allegatons of		
	10:30 P.M. a thi	rd shift (staff #5) called			abuse, neglect, and mistreatment reported immediately to the	is	
	the group home	manager to report he had			appropriate enttes .		
	1 ~ ^	cident from the morning			Whati is tihe datie by which tihe		
	of 8/11/11 betwe	een [client #1] and [staff			systiemic changes will be		
	1	ed (staff #10) had been			completied		
	1 1	to [client #1]. He had			10/2/11		
	1 *	#10] standing within an					
	inch of [client #1's] face yelling at [client #1] for about 2 minutes. He (staff #5)						
	1 2	that she (staff #10) then					
	1 ^	, ,					
	,	#1) to his room to calm					
	1	n hour. [Staff #10] was					
	suspended from duty beginning 8/12/11						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G121		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 09/14/2	LETED	
NAME OF PROVIDER OR SUPPLIER PASSAGES INC			125 NO	ADDRESS, CITY, STATE, ZIP COE PRTH 200 EAST MBIA CITY, IN46725	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
l	pending the outcome pending the following the true per the pending the true pending the p	ome of the investigation." Y-up report dated 8/16/11 Itowing: "Staff was not diately when [client #1] due to the uncertainty of thThe staff that dent was counseled on aportance of reporting iately." Y-up report dated 8/16/11 Itowing: "On 8/11/11 [staff o shifts 6:45 A.M8:15 incident occurred) and P.M Staff #10 also M 8:15 A.M. on egation of abuse was d staff #10 was 15/11.		CROSS-REFERENCED TO THE APP		1
	3/11, was review A.M The policy "It is the policy abuse/neglect of tolerated, and the abuse/neglect or persons served b authorities to enshuman rights	ation, Etc. policy dated red on 9/14/11 at 9:20 red indicated the following: of [Name of facility] that clients served will not be at all reports of other incidents involving the reported to the proper sure the protection of any staff who suspects an victim of abuse or				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		15G121	B. WING 09/14/2011			011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			RTH 200 EAST		
PASSAG	SES INC				IBIA CITY, IN46725		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	neglect shall rep	•					
	suspected of abu	se, neglect or exploitation					
	will be suspende	d until the case is fully					
	investigated [nar	ne of facility] will					
	1 -	person from direct					
	contact with con	-					
	Contact with Con	Sum 015					
		1 (1 :4 4					
		s conducted with the					
	`	1 at 1:40 P.M When					
	asked if staff had	l followed the agency					
	policy the QDDI	P stated, "No." The QDDP					
	indicated they had completed an investigation and the allegation was found						
	_	ed. The QDDP indicated					
		ntinued to work in the					
		t #1 had made the					
	1 -	QDDP indicated staff #5					
	had not immedia	tely reported the incident					
	of abuse between	n client #1 and staff #10.					
	1.1-3-2(a)						
	1.1-3-2(a)						
W0153	The facility must e	ensure that all allegations of					
	_	lect or abuse, as well as					
	1 -	n source, are reported					
	1	administrator or to other					
		ance with State law through					
	established proce		1177	1152	Milesti competitive and of Access to		10/02/2011
		review and interview, the	w)153	Whati corrective action(s) will be	ic	10/02/2011
	tacility failed to	ensure an allegation of			accomplished fior tihese resident	15	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		15G121	B. WING 09/14/2		09/14/2	011	
		l .	D. ((11)		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF 1	PROVIDER OR SUPPLIEF	8		1	RTH 200 EAST		
PASSAG	SES INC				IBIA CITY, IN46725		
		TATE AND DEPOSIT OF DE	_		- ,		(37.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
1710		ving 1 of 4 sampled	+	1710	fiound tio have been afiectied by	tibo	BittE
		•			deficienti practice	une	
	`) was immediately			Staft who observed incident oft at	ouse	
	1 -	dministrator and the			was retrained on Passages policy o		
		opmental Disabilities			reportng incidents oft abuse,		
	`) reports as evidenced in			neglect, mistreatment immediatel	y.	
	1 of 24 BDDS re	eports reviewed, in			How will we identifiy otihers		
	accordance with	state law.			residentis having tihe potiential t	io be	
					afiectied by tihe same deficienti		
	Findings include	:			practice:		
					All staft was provided training on		
	 Facility records :	were reviewed on 9/13/11			Passages policy oft reporting		
	1 -	uding the BDDS reports			incidents oft abuse neglect,		
					mistreatment immediately.		
		es of 11/10/10 and			Whati measures will be puti intio place or whati systiemic changes		
		DS reports indicated the			be made tio ensure tihati tihe	wiii	
	following:				deficienti practices do noti recur		
					All allegatons oft abuse, neglect, a	nd	
	- a BDDS report	dated 8/12/11 for an			mistreatment will be reported to t		
	incident on 8/11/	11 at 7:15 A.M. indicated			appropriate enttes immediately po		
	"On 8/11/11 [clie	ent #1] reported to the			agency policy.		
	_	opmental Disabilities			How will tihe corrective actions b	e	
		ODP) that he had a			monitiored tio ensure tihe deficie	nti	
	` ~	roup home this morning			practice will noti recur		
					QDDP will ensure all allegatons of		
	1 *	Client #1] said he got up			abuse, neglect, and mistreatment		
	1	nower in the morning			reported immediately per Passage	!S	
		ng to be out with his			policy.		
		ernoon, when it was his		QDDP will ensure staft receives training upon hire and annually			
	assigned shower time. A staff member				thereafter on Passages policy oft		
	[staff #10] 'got in my face and was yelling				reporting incidents oft abuse,		
	at me and being disrespectful to me.' An				neglect, and mistreatment		
	investigation was started. On 8/11/11 at				immediately.		
	1 -	rd shift (staff #5) called			Whati is tihe datie by which tihe		
		manager to report he had			systiemic changes will be		
	1 ~ 1	cident from the morning			completied		
		en [client #1] and [staff			10/2/11		
	1 51 5/11/11 betwee	on Londin 11 and Louin					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G121		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL 09/14/2	ETED	
	156121		B. WIN			09/14/2	011
NAME OF PROVIDER OR SUPPLIER				125 NO	ADDRESS, CITY, STATE, ZIP CODE PRTH 200 EAST		
PASSAG	ES INC			COLUM	IBIA CITY, IN46725		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1 - 1	d (staff #10) had been					
	1	to [client #1]. He had					
	-	10] standing within an					
	-	's] face yelling at [client					
		ninutes. He (staff #5)					
	_	that she (staff #10) then					
	`	‡1) to his room to calm					
		hour. [Staff #10] was					
	_	duty beginning 8/12/11					
	pending the outc	ome of the investigation."					
	- a BDDS follow-up report dated 8/16/11 indicated the following: "Staff was not						
	suspended imme	diately when [client #1]					
	_	lue to the uncertainty of					
	1 ^	1] was exaggerating or					
	_	thThe staff that					
	1	dent was counseled on					
	1 ^	nportance of reporting					
	incidents immed						
		, and the second					
	An interview was	s conducted with the					
		1 at 1:40 P.M The					
	`	they had completed an					
	,	the allegation was found					
		ed. The QDDP indicated					
		mmediately reported the					
		between client #1 and					
	staff #10.	The state of the s					
	1.1-3-2(a)						
	•						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G121		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/14/2011	
NAME OF PROVIDER OR SUPPLIER PASSAGES INC			125 NO	ADDRESS, CITY, STATE, ZIP CODE PRTH 200 EAST MBIA CITY, IN46725	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
W0155	Based on record facility failed to staff to ensure the potential abuse a clients (client #1 staff abuse. Findings include Facility records vat 1:59 P.M. include the date 9/13/11. The BD following: - a BDDS report incident on 8/11/1 [client Qualified Develor Professional (QE situation in the guard to take a shum since he was goin mother in the after assigned shower	revent further potential vestigation is in progress. review and interview, the immediately suspend a e possibility of further fter 1 of 4 sampled) made an allegation of were reviewed on 9/13/11 uding the BDDS reports sof 11/10/10 and DS reports indicated the dated 8/12/11 for an 11 at 7:15 A.M. indicated ent #1] reported to the pomental Disabilities DDP) that he had a roup home this morning Client #1] said he got up ower in the morning are the morni	W0155	Whati corrective actior(s) will be accomplished fior tihese resident fiound tio have been affectied by deficienti practice Employees who are alleged to hat engaged in abuse, neglect, or mistreatment will be suspended immediately pending the outcom oft a thorough investgaton. How will we identify others residentis having tihe potiential affectied by tihe same deficienti practice: Employees who are alleged to hat engaged in abuse, neglect, or mistreatment will be suspended immediately pending the outcom oft a thorough investgaton. Whati measures will be put intiplace or whati systiemic changes be made tio ensure tihati tihe deficienti practices do noti recur Staft training regarding Passages policy regarding abuse, neglect, a mistreatment will be provided up hire and annually thereafter. How will tihe corrective actions monitiored tio ensure tihe deficient practice will noti recur QDDP will ensure all policies related abuse, neglect, and mistreatment is being ftollowed	tis y tihe ve tio be te s will and bon be enti ted

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G121		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/14/2011				
NAME OF I	PROVIDER OR SUPPLIER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 125 NORTH 200 EAST COLUMBIA CITY, IN46725					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	at me and being investigation was 10:30 P.M. a thir the group home in witnessed the inco of 8/11/11 betwee #10]. He reported verbally abusive observed [staff # inch of [client #1 #1] for about 2 in further reported to sent him (client # down for over an suspended from opending the outcome and the suspended imme made his reported the incidents immediately inclient # falsifying the true reported the incidents immediately inclients immediately worked the foll #10] worked two A.M. (when the incidents immediately inclients inclients immediately inclients	disrespectful to me.' An a started. On 8/11/11 at and shift (staff #5) called manager to report he had eident from the morning en [client #1] and [staff and (staff #10) had been to [client #1]. He had 10] standing within an 's] face yelling at [client minutes. He (staff #5) that she (staff #10) then a hour. [Staff #10] was duty beginning 8/12/11 ome of the investigation." 1-up report dated 8/16/11 owing: "Staff was not diately when [client #1] due to the uncertainty of 11] was exaggerating or thThe staff that dent was counseled on apportance of reporting		QDDP will ensure training is provided regarding Passages abu neglect, and mistreatment policy upon hire and annually thereafte reviewing training documentator annually and when new employe are hired. Whati is tihe datie by which tihe systiemic changes will be completied 10/2/11	r by n es			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G121		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED /2011	
NAME OF PROVIDER OR SUPPLIER PASSAGES INC			125 NC	ADDRESS, CITY, STATE, ZIP CO ORTH 200 EAST MBIA CITY, IN46725	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	substantiated, an terminated on 8/					
	QDDP on 9/14/1 QDDP indicated investigation and to be substantiate staff #10 had con	s conducted with the 1 at 1:40 P.M The they had completed an I the allegation was found ed. The QDDP indicated attinued to work in the t #1 had made the				